TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Trenton D. Weeks, D.C.

Respondent Name
Ascension Health

MFDR Tracking Number
M4-15-1932-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
February 27, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Having a DD examination does not negate the injured employee's entitlement to subsequent MMI/IR evaluations by certified doctor."

Amount in Dispute: $350.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier asserts that Requestor is not entitled to reimbursement for the March 4, 2014 exam because it does not fit under the criteria of Section 408.004(f-2)…

Dr. Weeks' evaluation is not valid as he included in the evaluation alleged L3-4 and L4-5 herniations. These conditions were found to not be compensable by a CCH decision…"

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 4, 2014	Referral Doctor Examination to Determine MMI/IR	$350.00	$350.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for Division-specific services.
3. 28 Texas Administrative Code §19.2005 sets out the general standards of utilization review.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 50 – These are non-covered services because this is not deemed a medical necessity by the payer.
   - 216 – Based on the findings of a review organization.

- PI – These are adjustments initiated by the payer, for such reasons as billing errors or services that are considered not reasonable or necessary.

Issues

1. Does an unresolved extent of injury issue exist for this dispute?
2. Are the insurance carrier's reasons for denial of payment supported?
3. What is the Maximum Allowable Reimbursement (MAR) for the disputed services?
4. Is the requestor entitled to additional reimbursement?

Findings

1. In their position statement, the insurance carrier argues that conditions listed for the services in question "were found to not be compensable by a CCH decision…" 28 Texas Administrative Code §133.307 (d)(2)(F) states, in relevant part, "The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review…"

   Review of the submitted documentation finds that the denial reasons presented to the requestor prior to the request for MFDR did not include extent of injury. Therefore, this issue will not be considered for this dispute.

2. The insurance carrier denied disputed services with claim adjustment reason codes 50 – "THESE ARE NON-COVERED SERVICES BECAUSE THIS IS NOT DEEMED A MEDICAL NECESSITY BY THE PAYER," and 216 – "Based on the findings of a review organization." 28 Texas Administrative Code §133.307 (d)(2)(I) requires that "If the medical fee dispute involves medical necessity issues, the insurance carrier shall attach a copy of documentation that supports an adverse determination in accordance with §19.2005 of this title..."

   Review of the submitted information does not find documentation to support an adverse determination. The insurance carrier's denial reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

3. This dispute involves an examination by a doctor, other than the treating doctor, to determine maximum medical improvement (MMI) and impairment rating (IR), CPT code 99456-NM. 28 Texas Administrative Code §134.204 (j)(2)(A) states,

   > If the examining doctor, other than the treating doctor, determines MMI has not been reached, the MMI evaluation portion of the examination shall be billed and reimbursed in accordance with paragraph (3) of this subsection. Modifier "NM" shall be added.

   28 Texas Administrative Code §134.204 (j)(3) states,

   > The following applies for billing and reimbursement of an MMI evaluation…
   >
   > (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350.

   Review of the submitted documentation supports that the requestor performed an examination to determine MMI, finding that the injured employee was not at MMI. Therefore, the total MAR is $350.00.

4. The total MAR for the disputed service is $350.00. The insurance carrier paid $0.00. A reimbursement of $350.00 is recommended.

Conclusion

While not all evidence was discussed, it was considered. For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $350.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $350.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	October 9, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.